ST JOHN OF GOD
Frankston Rehabilitation Hospital

Palliative care referral

Admission criteria:
- Patient has a progressive, life limiting illness
- Patient or their decision maker is aware of, understands and has agreed to a palliative admission
- Goals of care have been discussed, patient is being admitted for optimal comfort treatment in the terminal phase

Patient Details:

Full name: _____

DOB: _____

Phone: _____

Address: _____

_____

Suburb: _____ State: _____

Postcode: _____

Medicare number: _____

Health fund name: _____

Health fund number: _____

Current location: _____

Lives alone: Yes ☐ No ☐

Currently lives with: _____

Interpreter required: Yes ☐ No ☐

Indigenous status: Yes ☐ No ☐

Cultural requirements: _____

_____

Medical Details:

Diagnosis

_____

_____

_____

_____

☐ Comorbidities (please list below)

☐ Allergies (please list below)

Reason for referral

☐ Speech / swallow difficulties
☐ Dietary requirement
☐ Nausea
☐ Pain
☐ Gastrointestinal
☐ Neurological
☐ Terminal care

Additional information
(please provide copies)

☐ Correspondence
☐ Advance care plan / Directive
☐ Medication list
☐ Last Cytotoxic
☐ Date for last therapy _____
☐ Alerts
☐ Specific care / Equipment required

Goals of care:

_____

_____

_____

_____

Primary contact/ Next of Kin:

Full name: _____

Phone: _____

Medical Power of attorney: Yes ☐ No ☐

Referring Doctor Details:

Full name: _____

Phone: _____

Provider number: _____

GP / Oncologist details:

Name: _____

Contact number: _____

☐ Referral from home

☐ Referral from hospital
Contact number: _____

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